82-1217

No.

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1983

SEYMOUR R. MATANKY, M.D. and
CORBIN MEDICAL CLINIC,

Petitioners,

vs.

UNITED STATES OF AMERICA,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND BLUE SHIELD OF
CALIFORNIA, a corporation,

Respondents.

Judicial Review Pursuant to Article III,
U.S. Constitution and Title 28 U.S.C., Section 1491, and
Fifth Amendment, U.S. Constitution of Medicare Act, Part B
Claims Administrative Review

SUPPLEMENTAL EXHIBITS TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT, AND TO THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

JOAN CELIA LAVINE
Attorney at Law
123 North Hobart Boulevard
Los Angeles, California 90004
(213) 627-3241

Attorney for Petitioners
Seymour R. Matanky M.D., and
Corbin Medical Clinic

VOLUME II of II

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT
717 MADISON PLACE, N.W.
WASHINGTON, D.C. 20439

October 22, 1982

GEORGE E. HUTCHINSON
CLERK

TELEPHONE: 633-6550
AREA CODE 202

Morris Lavine, Esq.
123 North Hobard Blvd.
Los Angeles, CA 90004

Re: Case No. 67-80 C
Matanky et al. v. United States

Dear Mr. Lavine:

The court denied today the petition for reharing in the above appeal.

Very truly yours,

/s/ George E. Hutchinson
Clerk

cc: David M. Cohen, Esq.
Department of Justice

NAHMAN SCHOCHET
MEDICARE HEARING OFFICER
Two North Point
San Francisco, California 94133

October 25, 1978

Joan Celia Lavine, Attorney
617 South Olive Street, Suite 510
Los Angeles, CA 90014

Re: Seymour R. Matanky, M.D.

Payment Review (PARE) on multiple beneficiaries services May 1969 through June 1973, with beneficiaries' names, HIC numbers, and claim control numbers in the record exhibits and accounts.

Amount in controversy at hearing request: net Medicare refunds due of $50,889.82 (the net 80% paid on the total reviewed overallowances).

FAIR HEARING CASE NUMBER 78268 (originally 77042)

On August 7, 1978, hearing was duly held at Los Angeles, California pursuant to Part B, Title XVIII of the Social Security Act, as amended, and regulations, policy and guidelines duly adopted

thereunder. The participants were: claimant in person; his attorney/representative, Ms. Joan Celia Lavine, of the Morris Lavine and Joan Celia Lavine Law Office; Mr. Claude Molaison, representative of the carrier, Blue Shield of California; Mr. John I. Jefsen of the Law Office of Hassard, Bonnington, Rogers & Huber, the carrier's attorney; and Doctor Julius Sherr, M.D., a medical advisor who reviewed the claims and files herein for the carrier.

The record herein consists of:

> Exhibit A, the original file and claim accounts, previously furnished claimant and his attorneys. Included are the claims from May 1967 through June 1973 (in 65 different months) which were questioned. Also included herein is an additional August 7, 1978 letter with 15 pages of Committee Case Computations attached to the Administrative Review Decision of September 30,

1976 mailed to Doctor Matanky (the claimant), and to be associated with pages 16-18 of the file (Exhibit A).

Exhibit B: Carrier's 4 page June 1, 1970 Medicare Bulletin; Part By Intermediary Letter Number 70-32, Number 70-32, Number 70, pages B5 through B9; and carrier's January 1971 Medicare Bulletin pages 10 AND FF.

Mr. Schochet:

On the claim of Seymoure R. Matanky, Doctor of Medicine, apparently doing business or has done business at the Corbin Medical Clinic. Multiple patients accounts on fault herein will not be listed or named at this time. This is Fair Hearing Case Number 77042 pursuant to Part B, Title XVIII of the Social Security Act as amended and regulations duly adopted thereunder. I am Nahman Schochet, Hearing Officer assigned to this case since the early summer of 1977. The claimant is present in

person represented by his attorney Joan C. Lavine. The carrier, Blue Shield of California is represented by Claude Molaison and attorney John I. Jefsen. Also present is Doctor Julius Sherr a medical advisor for the carrier who has reviewed the file herein. My information of the case is from the material contained in the file furnished the parties, this is quite bulky but it will be considered Exhibit A for the record to keep it separate from any additional Exhibits that may be submitted.

The proceedings are tape recorded, all statements made on record are subject to the Federal Regulations governing the giving of false evidence. The purpose is to furnish claimant his requested opportunity to explain his position with such additional evidence as is pertinent and not already on file to support the claim he made. Claimant alleges that moneys withheld by the carrier for Medicare services are due him without any further adjustments. Normally it is not

advisable and necessary to go into any details at this time but reciting some of the background facts should help avoid unnecessary repetition of history during the hearing, as well as refresh memories of those present that the claimant has considerable arguments already on record in the Exhibit.

Medicare reimbursement for claimant were withheldheld for at least since June 1971 at the direction of the Social Security Administration, Bureau of Health Insurance. The carrier was also directed to perform a post-payment review of all services between 1967 and 1973 rendered in skilled nursing and similar facilities. The resulting determination originally was that claimant has been over-paid somewhat over $51,000.00. $1,634.72 withheld over that amount was paid with an August 25, 1975 letter. Since then the files have been reviewed and re-evaluated. A September 1976 letter requests that 2414 claims involving services for 305 Medicare beneficiaries

were reviewed in so far as Medicare was involved with the reviews of all billings for services in skilled nursing facilities, nursing homes and guest homes. This was done by a medical advisor in claimant's specialty, evaluating the medical necessity of multiple visits. Pre-administrative review indicates as I have said over $50,889.82 overpaid and that apparently is our figure where we start today. From some experience in these cases, let me say on the record that such review is not to check on claimant's medical or professional ability or practice. The overpayments usually come from such causes as using the wrong procedure number, insufficient documentation, more visits charged to Medicare than allowable normally and such similar causes.
No argument is intended in this statement, it is simply a brief resume of the basic facts showing why the carrier performed this audit as directed by the Medicare agency and what the background is. Is this satisfactory for that purpose Ms. Lavine.

I'm not really asking for a commitment; this is just a general type background.

Ms. Lavine:

As far as it goes, yes.

Mr. Schochet:

And that's all the farther it is going to go. Is that alright with you Mr. Jefsen?

Mr. Jefsen:

Yes sir.

Mr. Schochet:

Alright, now then we can get down to the matter for which we're gathered. As you have been advised the procedure is fairly informal, we will withhold any technical arguments and try to get the facts on record for consideration. Now the claimant, Doctor Matanky, and his attorney at that time, Mr. Morris Lavine, asked for this hearing and after a number of difficulties we are finally gathered today. What should we put on to record, Ms. Lavine,

that is not there now to explain the claimant's position of this matter?

Ms. Lavine:

There are several items, your honor, first of all I think that we should consider the evidenciary matters which I understand will be put into evidence; all of the claims and copies of checks paid out and the information on them and the item called.....I am not sure, we were looking at it here earlier this morning. Labelled Hearing File Number 1, Fair Hearing Case Number 77042 is the title of it, Seymour R. Matanky, M.D. I believe that we need to take into consideration the various dates involved with notification, of what the notification consisted of, to whom notification was given and what regulations or rules were in effect that could adversely have effected Doctor Matanky at the time these various factual matters occured. Now I say this in a very conclusionary matter because I really need to

examine Doctor Matanky and go through these a little bit more specifically. Would you prefer that I do that now?

Mr. Schochet:

Well now let me pause there a minute; are you proposing at this time to go into all of those details that should have been done a long time before this, that should be normally established by the correspondence on file, by the notices to Doctor Matanky, by his objections, by the letters from your office? Isn't that repetitious and unnecessary?

Ms. Lavine:

Yes, I am just asking you if you would prefer that I do that, or we can just simply stand on the evidence that is, that I am pointing out to you that we had earlier discussed would be appropriate.

Mr. Schochet:

I think that if you believe there are serious errors affecting your clients rights they should

be pointed out. But to review the whole thing from A through Z, I think, would verge on nonsense at this time because it is not that type of hearing. You have the, Doctor Matanky according to my recollection, and this is without a final commitment until I re-review the file, has been on notice since the mmiddle of 1971, this has been in the nature of what the law refers to as an ongoing audit and as the correspondence back and forth and your firm has sent us some fairly lengthy and complete arguments from time to time and they have been read and I have read them all over and will do so again. So, I dont't see any point unless it is just to kill time and I am sure you don't want to do that. My idea of a hearing of this type is that, at this time, if there is anything that has been omitted from the file that is not sufficiently indicated even though it might be intimated that might harm the claimant's case, then I think you should put those on the record now.

Ms. Lavine:

Very well. I would like to point out to you various factual matters which appear to be very serious jurisdictional and due process omissions on a part of Blue Shield and the Social Security Administration. It appears to me from the record that although Doctor Matanky is right now characterized as the claimant, the original claimants who were the patients of Doctor Matanky have never been notified that there was a review going on after an initial determination had occurred. I cannot find any indication that any of his patients between 1967 and 1972 were ever notified of that. Second, it appears that what actually occurred was that Blue Shield, or the carrier, took payment from one set of patients and offset them against payment that has already been made, vis-a-vis, apparently another group of patients. Sometimes there may have been some general overlaping, it is hard

to tell, but there was apparently no notice to the subsequent patients involving subsequent applications for payment that their payments were being withheld from Doctor Matanky. I believe that the rules and regulations require at a reopening but all of the parties; and that includes the patients, be notified that this was occurring. That is my first concern. Now I have studied these rules and regulations concerning the suspension of payment and I understand that the only regulation that I can find that could have adversly affected Doctor Matanky was not published in the Federal Register until January 5, 1972, being in volume 37 starting at page 89 of the Federal Register. It appears that this rule required that Doctor Matanky be given notice and the opportunity to present evidence if you were going to be withholding, but this regulation does not appear to have gone into effect until after he was given notice of a suspension which I don't believe was

authorized by law. Even the provision that was put into effect as I understand it requires a conforming due process of law in that Doctor Matanky and the patients involved be given notice and the opportunity to be heard prior to any withholding of funds. This would mean that both the patients about whom there were payment disputes and the patients whose funds were going to be withheld for supposed recoupment be given notice. I do not find that this has been done at all from the record.

Mr. Schochet:

Just a minute, in regards to such claims, were these claims submitted in the name of Doctor Matanky?

Ms. Lavine:

Some were submitted in the name of Doctor Matanky, and some in the name of Corbin Medical Clinic.

Mr. Schochet:

Alright, so how was the patient involved in so far as the payment of these moneys was concerned?

Ms. Lavine:

How was the patient involved?

Mr. Schochet:

I mean Doctor Matanky was the person that billed, he was the person that asked payment, he was the person that complained of the adjustments or disallowances.

Ms. Lavine:

Your asking me what the involvement of the patient would be?

Mr. Schochet:

That's right.

Ms. Lavine:

The involvement of the patient is two fold.

Mr. Schochet:

But they were liable for the balances of course.

Ms. Lavine:

They were obligated for 20% of the bill to begin with but, I think there is something much more serious involved here. There was a contract between Doctor Matanky and his patients for Doctor Matanky to be paid a reasonable value of his services and I think the patient was entitled to know if his bill was not being paid according to the agreement that the patient had with Doctor Matanky I believe that any.....

Mr. Schochet:

Are you saying that Doctor Matanky did not notify them?

Ms. Lavine:

It wasn't Doctor Matanky's obligation to notify them.

Mr. Schochet:

In other words he did not notify them?

Ms. Lavine:

To the best of my knowledge no.

Mr. Schochet:

Ok. Now continue.

Ms. Lavine:

I do not believe that it was Doctor Matanky's obligation to have; the way I read the regulations, your honor, it was the obligation of the intermediary or Social Security Administration to have given notice.

Mr. Schochet:

Where did you find that?

Ms. Lavine:

Just a minute.

Mr. Schochet:

We are accepting this as argument.

Ms. Lavine:

This was only after the provisions went into effect. I don't find any provisions for suspension of payment prior to 1972 in the Social Security Administration regulations.

Mr. Schochet:

Ok. Continue.

Ms. Lavine:

May I point out that section to you at a little later time.

Mr. Schochet:

Yes.

Ms. Lavine:

Thank you. When I have had time to go through these regulations. Now, we get to another point involving review, and perhaps I should point out here that Mr. Jefsen has artculated that there was ongoing review involving an initial determination, but it is apparent that it was characterized as a recoupment for recovery procedure for supposed overpayment and I respectfully submit that this is actually a reopening of the various claims. The question becomes within what period of time, could these claims be reopened? Now that has caused me quite a little bit of problem in attempting to understand the various statutes of limitations involved but it would appear to me that

I can find no statement at all in the Federal Register referring to any right to reopen prior to about 1972. In 1972, I understand, that there was actually a provision instituted..... maybe I am misstating myself.....I'll have to check on the date on which the publication occurred.....

Mr. Schochet:

Did you run across anything under the title of Common Law Right of Recoupment in such cases?

Ms. Lavine:

I didn't research long enough on them.

Mr. Schochet:

There are some that are pretty involved. Go ahead.

Ms. Lavine:

The provisions that I did find though talked about the three year statute of limitation and for time periods commencing after May of 1972, there was.....No, I have misspoken myself,

for periods after December 31, 1971, there could be a reopening for three years prior and apparently what had to commence was a field audit within a three year time period as I understand the law. Prior to December 31, 1971, an audit, an indepth audit, had to occur or commence within a three year time period, if I understand the law to be correct, but again I want to point out to you I was unable to find anything published in the Federal Register about this three year time period prior to about 1971.

Mr. Schochet:

I thought you said 1972 earlier.

Ms. Lavine:

Yes. I said I misspoke myself.

Mr. Schochet:

1971 then.

Dr. Matanky:

On December 31, 1971.

Ms. Lavine:

That's right. I direct our attention to the Medicare/Medicaid guide in Commerce Clearing House. Paragraph 13510 discussing this matter and referring to a Medicare Intermediary Manual, Sections 2004 which I have never been able to locate and also referring within the Commerce Clearing House Medicare/Medicaid guide to paragraph 7635.87.

Mr. Schochet:

That's in Commerce Clearing House.

Ms. Lavine:

That's correct. Now the next question becomes what notice is adequate notice. As I understand it, the Blue Shield people, Social Security Administration believes a letter which is on page 1 of hearing file number 1 was intended to be notice and it reads, the body of the letter reads "Dear Doctor Matanky, we have been requested by the Social Security Administration to withhold Medicare reimbursement to

you pending the completion of an investigation of your claims to determine whether or not an irregularity exists. We will notify you when a decision is reached by Social Security Administration."

Now that is the body of the letter and it is signed Jane I. Csiteji, Program Supervisor, Program Integrity, Medicare Liaison, dated June 15, 1971. It is our position that this letter is not any due notice, reasonable or adequate notice to Doctor Matanky of which claims were being reviewed whether they were past claims or whether that would be the notice, of commencement of an ongoing audit of future claims, it did not give him any notice that he had the right to an evidenciary hearing or the right to review his. . . any disallowance of payments.

Mr. Schochet:

Just a minute, your putting in there as an assumption that the Doctor knew nothing at

all about Medicare, and had never been instructed as to its rules and regulations, had never been instructed as to its rules and regulations, had no experience therewith, but had to be notified every step of the way of all of these claims and the obligations of each party involved. Is that the implication there.

Ms. Lavine:

What I am saying to you is that this was not notice to him of which claims were being reviewed, but if whether there was any contest of prior claims at that time. I do not believe that this is a clear notice of which claims were being reopened, it does not use the word reopen, recoupment.

Mr. Schochet:

You also said they gave him no details of his rights; are you taking the position that he has to be read his rights at that stage of the game.

Ms. Lavine:

Yes, it is my position that he would be entitled to be notified that he had the right to an evidenciary hearing and he should have been given notice of where he could present evidence and under what circumstances. It's further, my contention that before any money was withheld from him he was entitled to a hearing, and I cite to your honor Goldberg vs Kelley, United States Supreme Court decision on that.

Mr. Schochet:

Just a minute. Wasn't that in a different field of law.

Ms. Lavine:

That's the principle applied.

Mr. Schochet:

Being favorable to the claimant of this case, but it was not applicable to this kind of a proceeding.

Ms. Lavine:

Well I believe that it is.

Mr. Schochet:

I thought that was a Welfare case, was it not . . .

Ms. Lavine:

It was a Welfare case.

Mr. Schochet:

Was SSI involved.

Ms. Lavine:

I don't recall that it was, no.

Mr. Schochet:

I think the limit of that and the later of the rules is strictly limited. I will have to double check that. What is your citation to that?

Ms. Lavine:

I will have to supply that to you later.

Mr. Schochet:

Your point there was that under Goldberv vs Kelly you should . . .

Ms. Lavine:

Yes. Prior to being deprived of property in the form of these Medicare payments for caring for these patients. Doctor Matanky was entitled to be notified of a right to a hearing and to be given a hearing at a reasonable time and reasonable place and in a reasonable way. I note that when there was a . . . I note that when there was a clarification or a publication of the Federal Register concerning the suspension of payments there was a provision starting with regulation number 5 of Section 405.370 through 405.372. My position is that I have a great deal of difficulty in understanding when Doctor Matanky was actually given notice of these recoupment procedures which until my father, Morris Lavine, commenced inquiries in 1974 as reflected by correspondence and I have difficulty in understanding how the three year time period is applied, how there can be any reopening at all.

Mr. Schochet:

Well, now instead of putting in pertinent evidence, what you are doing is repeating arguments which by the most part you have already made on record. Is that correct? Is that your intention now to list all your legal arguments? Or are you putting in evidence?

Ms. Lavine:

I'm arguing a point which does not appear clearly from the face of the records because you asked me to go ahead with pertinent points. Now I would like to ask Doctor Matanky to testifybriefly about his care.

Mr. Schochet:

About what?

Ms. Lavine:

About his care.

Mr. Schochet:

What do you mean by care? Care of the patients?

Ms. Lavine:

Yes.

Mr. Schochet:

Well, insofar as they apply to this specific . . . because when you say care of, I don't know if you mean his professional ability or . . .

Ms. Lavine:

No. The fact that he had made the visit and he believes they were medically necessary.

Mr. Schochet:

Go ahead.

Ms. Lavine:

Doctor Matanky just poked me and wanted me to point out to you a case which may be of help to you in studying this three year time period. It is in the new development volume of the Commece Clearing House, Medicare/ Medicaid Manual, and it's numbered 77-26.

Mr. Schochet:

What is the date of that publication please.

Ms. Lavine:

The date of the publication, lets see.

Mr. Schochet:

I mean where did you get it?

Ms. Lavine:

In the new development section.

Mr. Schochet:

Have you a photocopy of that page?

Ms. Lavine:

Yes I do and I think I also have a photocopy of the case.

Mr. Schochet:

Alright just a minute now. I just want to identify that page. What is the date that that page was published or distributed?

Ms. Lavine:

Either, probably in 1977 because it's from the new development. . .

Mr. Schochet:

Are you guessing. . . Let me see.

Ms. Lavine:

It's well because the date of the case is '77.

Mr. Schochet:

Well this was copywrite in 1978 and it's which period are you referring to on these two pages.

Ms. Lavine:

This page, that, that, and this.

Mr. Schochet:

That's on page 7641 and the date of the . . .

Ms. Lavine:

My law clerk has these two pages switched around this is the first page and this is the second page.

Mr. Schochet:

But normally at the top of every page in the CCH booklet of this type there is a date showing the week in which this was distributed that's what I am trying to find out.

Ms. Lavine:

I understand.

Mr. Schochet:

So I can locate it. So without that we will have to start at the very beginning.

Ms. Lavine:

Well I'll supply this to you in writing. But this has been compied from my own research I had not realized that you would like to examine it. We'll locate it for you and supply you with a copy of it.

Mr. Schochet:

Its not much of a reference. Continue.

Ms. Lavine:

Oh I'm sorry, I saw you writing. . . I didn't want to . . .

Mr. Schochet:

No I was just writing some notes. I thought you said you were going to ask Doctor Matanky some questions.

Ms. Lavine:

Yes. Doctor Matanky, concerning the patients that you saw between 1967 and 1973 that are involved with these claims, I want to ask you some questions generally that about your visits to them, were these for the most part, or were

these basically patients who were confined in hospitals or in convalescent homes?

Dr. Matanky:

That's correct.

Ms. Lavine:

And you saw these patients more than once a month for the most part as you've indicated in your claims, is that correct.

Dr. Matanky:

That's correct.

Ms. Lavine:

And why did you see these people more than once a month?

Dr. Matanky:

Well you mentioned '67 and I don't know whether there are some claims that they were auditing from '66 on too. But whatever the total number of claims from whatever period of time we are talking about. It's always been in my observation that the nature of caring for patients in Extended Care Facilities,

which these were, required a physician to be present and know what was going on to supervise the care and this could only properly be done by my presence. At least twice a week and sometimes more often and there were several reasons for this. First of all I have to identify the type of patients that we're dealing with. These were patients that were quite ill that had been in acute hospitals for the most part were daily attendance of these patients was necessary in order to insure that proper care, as required by hospitals of the acute nature and then they're transferred to Extended Care Facilities where their care was still quite necessary and urgent to continue their rehabilitation and maintenance of their health. There were several different levels of care that a Medicare patient was entitled to, one was acute hospital extended care facility and then if they required a lesser form of care, there was instituted a procedure by the Health Department where, they, with my

concurrance will put patients into what they would call intermediary care which is a lower level of care and none of these patients are in that level. They also go another step down to board and care where their ambulatory but not really able to take care of their total needs and so they are inboard and care facilities and then there are other Medicare patients who are strictly ambulatory and are office patients. So that these patients have to be categorized in a fairly ill type of patient requiring a considerable amount of care and attention for their various illness. And the other part of the problem is, is an ongoing thing that anyone has read the papers is familiar with the extended care facilities is totally aware of the really relatively poor level of medical care that is being given to these patients. This has hit the newspapers on many occassions. That the amount in trained personnel and so forth that they have in those facilities is, is something

to be desired. You have for the most part and still is an ongoing problem . . .

Mr. Schochet:

Just a minute, let's accept your statement is that your saying that in effect that for every single patient listed on all of these claims you found it necessary to visit them twice or more monthly . . .

Dr. Matanky:

Twice or more a week.

Mr. Schochet:

A week, alright . . .

Dr. Matanky:

For medical reasons.

Mr. Schochet:

Alright now continue.

Dr. Matanky:

Ok and for the additional medical reasons that they were not being afforded the same level of care that they were in acute hospitals. So that I would have to come in, find out if

the nurses and aids were carrying out my orders because frequently the level of trained personnel that was in these convalescent hospitals was much less then the acute hospitals you have people who . . .

Mr. Schochet:

I don't want to stop you doctor. I'll say this so far as I am concerned I am accepting your statement, your testifying just as though you are under oath, that for every single patient involved on all these multiple claims you found it necessary to visit them as often as you billed.

Dr. Matanky:

Right.

Mr. Schochet:

So there is no more details on that please. Now go ahead with anything else that you consider has been left off.

Dr. Matanky:

Alright that, that's my position if you want

to have to ask me any questions then I'll go from there.

Mr. Schochet:

Well now do you remember all of these patients?

Dr. Matanky:

I remember a fair number of patients but also I am trying to give you the general picture . . .

Mr. Schochet:

I understand your position your position is that these bills were justified and I'm not arguing with that . . .

Dr. Matanky:

That's right and their justified because of the fact that I, in order to render proper medical care which we're entrusted to do as physicians, we have to see these patients more frequently then what has been subsequently established as a rule.

Mr. Schochet:

Now your repeating yourself. In other words you are saying that Medicare rules does not

agree with your idea of the practice of medicine.

Dr. Matanky:

That's correct.

Mr. Schochet:

Alright so let us go ahead. Do you have anything else to say that has been omitted.

Ms. Lavine:

Yes, do you want me to . . .

Mr. Schochet:

I don't want anymore repitition because . . .

Ms. Lavine:

I appreciate that, I appreciate that. Mr. Jefsen, there was no dispute that he about his actually having made the visits is that correct?

Mr. Jefsen:

We are not questioning that at this time.

Mr. Schochet:

I reserve a right to question it.

Mr. Jefsen:

And I don't guess, no what I'm saying is that

I understand Blue Shield's position at the present time that they are not taking a position on that.

Mr. Molaison:

No, we were instructed by the Medicare Bureau to overlook, not overlook, not to consider the fact, that whether or not the services had actually been rendered but to reajudicate the claims strictly on the basis for the medical necessity for the number of visits rendered.

Mr. Schochet:

Do you have any questions to ask on that connection Mr. Jefsen?

Mr. Jefsen:

And what connection as to whether or not the claims were . . .

Mr. Schochet:

Were medically necessary and properly submitted.

Mr. Jefsen:

Maybe I'll . . . I think we can stand, Doctor Sherr if we cannot, just on the claims themselves

as they are submitted can we? Do you have any further questions you would want to ask of Doctor Matanky?

Dr. Sherr:

No I the claims just simply state that there are so many calls of the guidelines of the rules and regulations of Medicare and Blue Shield Medical Policy and Medicare's Bureau of Medical Claims and the Department of Health for Medi-Cal Claims give us certain guidelines, we have to follow those, and it's not just a doctor it's all doctors, including myself, because I to had a similar, almost identical type of practice.

Mr. Jefsen:

I have no further . . .

Mr. Schochet:

I have something I want to clear up I can't quite understand this fact on . . . Doctor Matanky you knew that you practiced under Medicare so far as these patients were concerned

or at least a portion of them did you not?

Dr. Matanky:

I, they were treated the same as any of my other patients.

Mr. Schochet:

No that doesn't . . . your evading the answer. Did you know that any of these patients were covered to any extent under Medicare?

Dr. Matanky:

Yes.

Mr. Schochet:

Alright that was my question. Were you at all familiar with Medicare rules?

Dr. Matanky:

Yes.

Mr. Schochet:

You knew that normally that only one visit a months was allowed to an institutional patient?

Dr. Matanky:

That is incorrect. Initially . . .

Mr. Schochet:

You did not know that?

Dr. Matanky:

That is not the rule or regulation or anything.

Mr. Schochet:

How would you state it then?

Dr. Matanky:

Initially in 1966 and 1967 there were many of us physicians and '68 and so forth has no guidelines from Blue Shield as to the number of visits that they wanted us to see the patients. These rules and regulations of one visit a month may be came on in 1971 something of this sort 1972 I don't recall exactly but this is long after the fact and we, among many other physicians, treated the patient according to what we thought was the medical necessity and what was good medical practice. As far as the rule of one per month that was a rule that came out, again, I am snot sure, maybe 1971 or 1972 and that rule is an

unfortunate rule, but that is about when it came out.

Mr. Schochet:

And did you honor that rule after it was adopted?

Dr. Matanky:

After it was adopted, I still continued to see my patients and I was probably seeing them about once a week and I was questioned informally and I told them well you pay me what you want but I basically want to see my patients so that I can know what is going on with these people in the convalsecent hospitals because I am appalled what is happening with the type of medical care that they are getting.

Mr. Schochet:

At that time were there any rules or facts to be divulged for example, if you saw only one patient on a visit to an institution or if you saw a number of patients?

Dr. Matanky:

This was only a Medi-Cal rule and we're speaking about Medicare at the present time.

Mr. Schochet:

There was no such Medicare rule . . .

Dr. Matanky:

As far as I know it was only applied and being told to me by the girl who fills out these forms that these were the Medi-Cal rule and was not a Medicare rule.

Mr. Schochet:

In other words you got that information from a girl who filled out the forms?

Dr. Matanky:

Yes. My office manager who, you know, I really didn't get totally involved with the mechanics of this I left this up to an office manager who would fill out these forms and try and guide me as to what the current rules and regulations were.

Mr. Schochet:

When you submitted bills for multiple visits, were there any additional comments made of the documentation? Did you list any other facts there?

Dr. Matanky:

Yes, we listed what we were treating the patients for and what . . .

Mr. Schochet:

That was on the bill, on the claim?

Dr. Matanky:

On the claim. But here my attorney is pointing out to me . . .

Mr.Schochet:

Well let the attorney point that out later just answer the question please.

Dr. Matanky:

The what?

Mr. Schochet:

I want you to try to stick to one thing at a time so that we can accomplish something.

Dr. Matanky:

Sure.

Mr. Schochet:

And you are starting to argue Law with me now.

Dr. Matanky:

Ok.

Mr. Schochet:

I asked you did you make any notes for example as to the condition as to the reason for the multiple visits and additional documentation other than a bill for a certain month that's all I want to know.

Dr. Matanky:

The only thing I listed was the diagnosis as I recall.

Ms. Lavine:

I don't think he understands you. Your referring to any place, where he made any other notations other then what's on the form.

Mr. Schochet:

No ma'am. I am not. The doctor said he was talking about the bills is that right?

Mr. Matanky:

Yes. That's correct.

Ms. Lavine:

Ok, excuse me.

Mr. Schochet:

And I am asking if on any of those bills you made any documentation as to the reasons for multiple visits; severities, some new condition, anything at all; and you say you recall, you think you did.

Dr. Matanky:

Yes, in the form of the diagnosis.

Mr. Jefsen:

I think maybe that was bothering me too. Was the diagnoses in all of these basically the same?

Dr. Matanky:

The diagnoses as a rule frequently was the same.

Mr. Jefsen:

Because that's my impression, Doctor Sherr, that basically that when we are talking about the number of visits per month the diagnoses was consistantly the same. Acute.

Dr. Sherr:

Well, usually it consited of a long list of diagnoses some chronic some acute and some not acute, some recent, but a long list repeated month after month after month.

Mr. Jefsen:

Visit after visit after visit.

Dr. Sherr:

Right.

Mr. Schochet:

Were they by patient or summary?

Dr. Sherr:

By patient, under the nature of illness or injury requiring servies of supplies.

Mr. Schochet:

Well that's what I have been trying to find

out. Now, what is it your lawyer wanted to . . .

Dr. Matanky:

Well, just to the time that the rule came down for one visit per month, and this was January 1, 1971.

Mr. Schochet:

What is your source for that?

Ms. Lavine:

Your honor, if I might hand it to you, this is from the letter from Blue Shield, it's on page 17 of the file #1, hearing file 1. I'll just hand it to you you can have a look at it here. This is a discussion about the various bases for dispute.

Mr. Schochet:

Well here it says, you are pointing this out as a rule?

Ms. Lavine:

No. This is the only guidance we have as to why and when they felt that only one visit

a month should be made.

Mr. Schochet:

And this is a letter dated in September on September 30, 1976 and you are now saying on record for your client, that this rule stated to be effective from 1967 through December 1970 was not known to your client until the last of September 1976? That whole paragraph? Isn't that what your saying?

Ms. Lavine:

No, that's not what I am saying. What I am saying is that the discussion . . . Doctor Matanky, . . . just a moment.

Dr. Matanky:

Ok.

Mr. Schochet:

Read the whole paragraph.

Dr. Matanky:

Ok, as far as the paragraph that I am referring to, the claims received after January 1, 1971 many . . .

Mr. Schochet:

No, that wasn't the paragraph that she pointed out to me.

Dr. Matanky:

That is the paragraph.

Mr. Schochet:

I thought you pointed out the one on . . .

Dr. Matanky:

No! No!

Mr. Schochet:

Alright.

Ms. Lavine:

I'm sorry.

Mr. Schochet:

Then we are referring to the second one claims received after January. Was that you first notice about them?

Dr. Matanky:

No I probably knew about that in '71 as I said, but that . . .

Mr. Schochet:

I always thought that first paragraph says that the patient must state on the claim form "Only patient seen" for an allowance of any procedure greater then certain numbers. Was that your practice?

Dr. Matanky:

This was first of all it was a practice that I left strictly up to my medical manager, you know, office manager, and I have recently, I personally don't know all these regulations nor these code numbers because I leave this up to my girls. I just recently asked my office manager Carmen about this first patient and subsequent patients and she told me this only applied to Medi-Cal patients and not Medicare patients. And this was just this last week, so I got to go on what she was telling me and . . .

Mr. Schochet:

You mean your taking your office girls word

instead of what's in the regulations affecting Medicare. Is that what your saying?

Dr. Matanky:

I don't know whether this affects Medicare or Medi-Cal.

Mr. Schochet:

Well do you know now? Whom are you dealing with at this hearing Doctor Matanky?

Dr. Matanky:

Medicare. Only Medicare.

Mr. Schochet:

Then what rules are to be presented at this hearing.

Dr. Matanky:

Ok the Medicare rule.

Mr. Schochet:

Then why do you bring Medi-Cal into it?

Dr. Matanky:

Well this is what she told me.

Mr. Schochet:

Because your office girl told you that. Now I

want to get one thing straight, you just testified that you left all the choice of the procedures numbers to your office girl.

Dr. Matanky:

That's correct.

Mr. Schochet:

And do you realize that that is probably where all the difficulty is?

Dr. Matanky:

Well I don't see . . .

Mr.Schochet:

At least a portion of it.

Dr. Matanky:

I sent my office girl to UCLA for extensive courses and all these things so that she is up all these regulations.

Mr. Schochet:

Well did you certify her to Medicare so that they should have accepted her word without question. Is that the idea?

Dr. Matanky:

I don't know what your referring to.

Mr. Schochet:

Well your taking position because she did this extra work, had this extra training; now whatever she did should have been binding under Medicare Administration.

Dr. Matanky:

Well I think she is knowledgeable and I . . .

Mr. Schochet:

I don't question that, but anybody can make mistakes and not every claim is involved so far as I know.

Dr. Matanky:

But in any event what I am saying is before 1971 there was no limitation on the number of visits to our patients. So that the audit review form '66 and on to '71 we had no knowledge that only one visit was being required. It was after January 1, 1971 that . . .

Mr. Schochet:

I have recorded your statement. Ok Ms. Lavine is there anything further?

Ms. Lavine:

Yes, I would like to ask Doctor Sherr a couple of questions if I might. Is that agreeable?

Mr. Schochet:

Are you through with Doctor Matanky?

Ms. Lavine:

Yes. At this point I am.

Mr. Schochet:

Well why not cover the whole ground or do you want to cover it piece meal?

Ms. Lavine:

I'd rather not do that.

Mr. Schochet:

Well go ahead and ask Doctor Sherr and we will see how it goes.

Ms. Lavine:

This is going to be very brief. Doctor Sherr when did you commence auditing Doctor

Matanky's Medicare claims?

"Unintelligible."

Mr. Schochet:

Just a minute everything you two are saying and whispering between you is going down into the record of the hearing. I just want you to know that but I want the attorney to put in the legal part . . . alright, Doctor.

Dr. Sherr:

The claims were reviewed by me from approximately January 1974.

Ms. Lavine:

When did you start working with Blue Shield to do that kind of work?

Dr. Sherr:

Oh I think I go back a little over six years.

Ms. Lavine:

Doctor Sherr, your a physician licensed to practice in the State of California?

Dr. Sherr:

Over 30 years.

Ms. Lavine:

Alright, you indicated . . .

Mr. Schochet:

Just a minute just a minute is it necessary to do that. Now I took the trouble to look up Doctor Matanky's qualifications in the AMA and I think you are just wasting time here. If you want to know go ahead if you haven't taken the trouble to look it up.

Dr. Sherr:

Also I think you have a statement answering question 2-6 presented by Doctor Matanky attorney to attorney.

Mr. Jefsen:

I think they were presented to myself and I quite candidly I don't know how thoroughly I may have answered these questions.

Dr. Sherr:

With regards to my background I thought you might have that.

Mr. Jefsen:

Well I have your background I'm not sure I supplied them with complete resume, Doctor.

Ms. Lavine:

I don't think you did.

Mr. Schochet:

There is a letter in the file, at least one letter to probably Mr. Morris Lavine, asking questions about myself, Mr. Jefsen I think, Doctor Sherr, and Mr. Molaison, anyway it's in the record. Go ahead please.

Ms. Lavine:

To the best of my knowledge we didn't receive, I recall receiving some descriptions about you, your honor. Mr. Jefsen did you send that?

Mr. Jefsen:

Candidly I don't think that I did send in the complete resume of Doctor Sherr.

Mr. Molaison:

There is some information in a letter dated . . .

Mr. Schochet:

Alright Ms. Lavine have you looked through the file?

Ms. Lavine:

The one that you have in your hand . . .

Mr. Schochet:

Your office correspondence.

Ms. Lavine;

And I think I've looked at just about everything.

Mr. Schochet:

Well, go ahead and ask the question.

Mr. Jefsen:

I do indicate that the medical advisor was Doctor Sherr, that he has been licensed in California since 1945 and his field is the general practice with a specialty in internal medicine. And he is a graduate of the California College of Medicine. And that's about the extent of the background I have given you.

Mr. Schochet:

What is that from so she can document it.

Mr. Jefsen:

Oh this is from my letter of October 19, 1977 to Mr. Lavine.

Mr. Schochet:

Is that satisfactory?

Ms. Lavine:

That's not really what I wanted . . . I wanted to inquire about his more recent exposure to Geriatrics Practice at the present, if you don't mind your honor. He's reviewing these claims as a medical advisor concerning Geriatric isn't that correct?

Mr. Schochet:

I do not know, are you taking a position that these are geriatric claims?

Ms. Lavine:

There basically that, yes.

Mr. Schochet:

That's on information from your client. That

will have to be limited, I don't think that its pertinent. Go on.

Ms. Lavine:

Doctor Sherr you have done a medical practice in the past that exposed you to considerable number of people who were confined in convalescent homes and who were elderly.

Dr. Sherr:

I found that when I got to Highland Park that 60% of my practice was geriatrics. Now that's a lot, that's more than most.

Ms. Lavine:

Do you still practice in Highland Park

Dr. Sherr:

No.

Ms. Lavine:

Are you pacticing in private practice now.

Dr. Sherr:

I had been until a treadmill test said stop for awhile

Ms. Lavine:

Now when did you stop . . .

Dr. Sherr:

Oh, just a few months, a couple of months.

Ms. Lavine:

So you entertain that during the 1960's and early 1970's you did a geriatric practice with about 60 percent of your patient.

Dr. Sherr:

A very active general practice.

Ms. Lavine:

Let's take a hypothetical, let's say I am 70 years old and I have had a stroke. I've been placed in a convalescent home by you. I'm not on Medicare, I'm paying you privately, and I have servere paralysis and I can't walk. I even have to be taken to the bathroom. But I'm stable. How frequently would you visit me a month, would you have during the early 70's have visited me?

Dr. Sherr:

First of all that's very, very hypothetical because if the patient has had a stroke, I don't think, if he just had a stroke, he certainly wouldn't be in a convalescent hospital. He would be in an acute hospital, until he was definitely stable to the point where he could be taken to a convalescent hospital.

Ms. Lavine:

Well let's say I had stablized sufficiently so that I didn't need the care of an acute hospital.

Dr. Sherr:

In an acute hospital we would see the patient almost daily. However, when we feel that there well enough to go to convalescent hospital we see that we admit them. We may see them once more that month, but generally, unless the patient has a problem, that is documented by the nurse or the patient has a temperature let's say bleeding . . . fell out of bed and

were notified, we respond at any time. Documentation is the answer. In other words, if there is a reason to see that patient, we can see them six times a month. But under ordinary circumstances when they are stable, they don't really need more than once a month care.

Ms. Lavine:

Then you feel that even if I were a private paying patient, now I'm not paying you through Medicare with no agreement for payment by that route. That you could adequately supervise me and make sure that I was doing as well as could be expected by seeing me just once a month?

Dr. Sherr:

Yes indeed, because your no farther than a telephone. You have to be able to rely upon your aids whether they are in an acute hospital or in a convalescent hospital.

Ms. Lavine:

Lets say that I were again over the age of 65, excuse me let me go back. Between the time period of 1966-1970, did you see your patients under the similar circumstances that I've described in the hypothetical, once a month in a convalescent hospital?

Dr. Sherr:

Generally yes. First of all most of the patients could'nt afford much more care unless it was absolutely necessary.

Ms. Lavine:

Was that the basis of why you didn't see them more than once a month?

Dr. Sherr:

No, the basis was whether they needed the care.

Ms. Lavine:

Highland Park is a rather average income area, isn't it?

Dr. Sherr:

That's a rather low income area.

Ms. Lavine:

Let me presume that I've gotten out of the hospital, I've been treated for diabetes and I'm over 65 and I'm a private paying patient. Would you see me more than once a month?

Dr. Sherr:

Not necessarily.

Ms. Lavine:

Not necessarily.

Dr. Sherr:

It depends upon the type of diabetes that the patient has, is it an insulin dependent diabetes?

Ms. Laveine:

Let me describe it to you. An insulin dependent diabetic, who is a brittle diabetic, in other words you know fluctuating severely under the Medicare regulations she would still be able to see the doctor more than once a month.

Dr. Sherr:

Compared to one who is, let's say, a fully stable diabetic, maturity onset, who is taking no medication, who is on diet alone or possibly maybe taking some oral medication and is well controlled. That patient doesn't even have to have a blood sugar but once every three months. Although, we do see them once a month. I think the regulations asked that we see them once a month. For the purpose Doctor Matanky mentioned that are they getting the proper care, looking at the records and things of this nature. But your brittle diabetic may need more care but that should be documented until the patient is stablized.

Ms. Lavine:

Your point is, that your trying to make with me is, that documentation is the key to whether or not doctor will be paid by Medicare.

Dr. Sherr:

That is the key to all payment as far as

Medicare or any other insurance company is concerned.

Ms. Lavine:

I have just one more question to ask of you for right now. Doctor Sherr, is the dispute right now over these claims involved in this hearing over the number of visits or over the amount that he was charging for the visits?

Dr. Sherr:

Well I don't think that the charges for the visits are of any importance to me, because it was my impression that the charges would be scaled down by the computer of Medi-Cal or Medicare as it went on through. I think there was a time that they paid the doctor for the total amount, whatever he billed, but I dont't think that that's the case now. But the number of visits without any documentation as to need, medical necessity would certainly have to be questioned, particularly if one bills for a single patient seeing visit by using

the RVS number that states that, and the law, the rules say, the guidelines say, that we must write only patient seen, if we see that patient alone. We might see sixty patients in one week or weekend, at some convalescent hospitals.

Ms. Lavine:

Thank you. There is one other questions I have to ask you before you were forced to stop your full time private practice, approximately how many patients do you have on the average each year? Between 1973 and 1977.

Dr. Sherr:

Well, you are forced to take more than you really want. But 30 to 40 patients a day, unfortunately.

Ms. Lavine:

In your office? Or throughout, between convalescent homes and in your office?

Dr. Sherr:

I'd say I'd include convalescent patients as well.

Ms. Lavine:

Thank you.

END OF SIDE TWO OF TAPE.#1

Mr. Schochet:

Well, I think we should have something on the record from Doctor Sherr as to the computations. What basis do you want to put that on Mr. Jefsen for the carrier.

Mr. Jefsen:

Alright, Doctor maybe even before we get there because I want to clarify in my own mind the answers that you gave to Ms. Lavine that were hypothetical questions, would your answers be basically the same if we were talking about the period of time from 67 through 70 as opposed to the 70s through 71, 72?

Dr. Sherr:

I think that if the claims are more or less comparable, definitely yes. But I have not seen, I don't believe I've seen those claims. The claims where there were four digits to the

RVS number, is that the ones your talking about?

Mr. Jefsen:

Yes.

Dr. Sherr:

Where as now there are five digits. I think there are very few of those that I saw at all of Doctor Matanky's. However, I've seen many of others and so, yes, I would say that they are comparable; it is just a matter of using the other case numbers.

Mr. Jefsen:

Can you very briefly describe for us how you proceeded through your review with Doctor Matanky's claims?

Dr. Sherr:

How I . . .

Mr. Jefsen:

Yes, just what the procedure was.

Dr. Sherr:

I proceeded to review laboriously. Because

claims have to be taken one by one, and you have to feel that it is your patient and so you first read the name and and have some idea of the age because it's a Medicare patient you know its geriatric and then you must look at the diagnosis and when you see that the diagnosis is a long protracted diagnoses desides taking time you have to go over it because among those there might be some clue as to the actual immediate necessity of seeing the patient. Like an acute this or that. When you see that the same diagnoses is repeated month after month after month and sometimes without even one single change of a word, you wonder how could a patient have an acute bronchitis for four or five months in a row. That doesn't . . . and four times a week. So, that is one of the bases on which we make up our mind. We also have regulations of the various agencies and we have the guidelines, like the one visit per month, and incidentally I think that you will find that even though the

doctor may not be individually advised officially by a letter from Blue Shield or such, we do have a Blue Shield letter that comes out for both Medi-Cal and Medicare; and in those changes of regulations and guidelines are listed and I remember that in our office we would take a flair red pencil and circle everything that referred to us because after all if it referred to an Eaucleation of an eye and we didn't even bother with it because we don't do it. If it referred to the number of visits, we circled it.

Mr. Jefsen:

Is the sum total, or your conclusion of your work, contained primarily in what they call the Calculation File Number 2?

Dr. Sherr:

That calculation file Number 2 . . .looking at it, looks like a maze to me. I'm pretty sure that it is, but there is no way of knowing exactly whether this is for any one paritcular

patient that I saw because you see obviously there are thousands of them.

Mr. Jefsen:

Yes. I gather in your review you did go through each set of claims and adjust each set of claims and look at the whole batch per patient as a whole.

Dr. Sherr:

Not just each set of claims but each and every individual claim.

Mr. Jefsen:

And when you finished with that information where did that then pass on to?

Dr. Sherr:

Well I left that with my aid and after it was changed and stamped with my stamp, I then gave those claims to my aid who then . . .

Mr. Jefsen:

There you are talking about the physical claims themselves.

Dr. Sherr:

My goodness, did I go through all those claims myself.

Mr. Jefsen:

Scares you. I think that's all I have of the doctor. I do have maybe just for everybody's edification, three documents which indicate in from June 1 of 1970 to 1971 the guidelines, and I like to call them guidelines more than regulations because it's not that you can't be paid for more than one visit per month, its that that's all you allow, your allowed without further explanation, both of them entitle Medicare. So I think maybe your office gal got confused and I would offer those.

Ms. Lavine:

Do I understand that this is the only form of publication and that it's not been published in the federal register?

Mr. Jefsen:

I'm sure it hasn't been published in that

format in the published register. I will not say that it has not been published in a different format in the register.

Mr. Schochet:

There is now accepted as additional evidence which will be grouped as Exhibit B, January 1971 and copy of the Medicare Bulletin from the California Physicians Service. Secondly on November . . . November 70 Part B Intermediary Letter #70-32 and a photostatic copy of a Medicare Bulletin issued by the carrier dated June 1, 1970 and these are all part B. These are being handed to Ms. Lavine so she can enter their titles.

Ms. Lavine:

Thank you.

Mr. Schochet:

Doctor Sherr before Ms. Lavine questions you, in going over these claims did you find any substantial differences in procedure numbers or amounts to be allowed over what was paid?

Dr. Sherr:

Differences in procedure numbers

Mr. Schochet:

Yes. The RVS procedure numbers.

Dr. Sherr:

Yes there were numerous RVS numbers that had to be changed. A great many of them were absolutely correct. However, the amounts are not changed by us. The doctors usually charges his what we consider as his usual and customary fee.

Mr. Schochet:

In other words you did not change the amount, you just changed the classification of that service, and then, am I to understand that if any amount was changed as the correct amount due that was done by a computer service later by the carrier?

Dr. Sherr:

Yes.

Mr. Schochet:

Is that the way it works?

Dr. Sherr:

I believe so.

Mr. Schochet:

Well, that's what I wanted to know.

Dr. Sherr:

Because the number may of been inappropriate so we changed it to a more appropriate number that would describe . . . would fit the service described.

Mr. Schochet:

Were you ever given a report as to what those totals amounted to or your work was just checking on the proper procedure numbers and those things are set in the amount changed?

Dr. Sherr:

If I'm not mistaken, my aid showed me a letter, a single letter, sometime ago stating a certain amount of recoupment. I don't recall what that total amount was, but I did recall that she

she put that across my desk. I don't have copies of them with me.

Mr. Schochet:

Your concern was then with only reclassifying these to see that the services were billed properly in accordance with Medicare rules so the proper payment would be allowed.

Dr. Sherr:

That's correct.

Mr. Schochet:

And that's the sum total.

Dr. Sherr:

That's right, that's exactly right.

Mr. Schochet:

Now Ms. Lavine you want a little recess so you may look those over or just make notes of them.

Ms. Lavine:

Yes I would like to read them over, could I have perhaps a minute or two?

Mr. Schochet:

Lets have a short recess while Ms. Lavine may look over these new Exhibits, So she can question Doctor Sherr.

Mr. Schochet:

Back on record again. I think we left off just where you were to start questioning Doctor Sherr or to continue.

Ms. Lavine:

Thank you your honor. Doctor Sherr, and if I might, your honor, I want to disgress back to what I planned to originally ask Doctor Sherr about when he started auditing or reviewing these records. Can you recall whether you were reviewing later records when you first started reviewing Doctor Matanky's records in January 1974?

Dr. Sherr:

No, I really can't tell you exactly, there are just so many that it's impossible for me to know, but it seems to me that they were the

claims as they came through. The current claims of that time. Now claims are generally anywhere from 30 to 90 days off. I think about that, maybe 60, something like that, so they were the claims that were current claims from a few months back.

Ms. Lavine:

I see. Thank you, and Doctor Sherr you were, or you have been in the past 3 or 4 years, working with Doctor Matanky's assistant in his office, Carmen, on how to prepare these claims and when it's appropriate for billing purposes. Haven't you?

Dr. Sherr:

No, I called from time to time, when there was a question, for instances a patient was hospitalized and surgery was done by another surgeon and usually the RVS number for the surgery includes the admitting of the patient to the hospital and all of the post-operative care so that another doctor does not and

cannot bill for admission and the post-operative care, because there would be two doctors, the surgeon and lets say the general practitioner or the internist. Unless there is documented evidence that, that care was needed, so I have to call from time to time and ask a few questions.

Ms. Lavine:

I see.

Dr. Sherr:

That was really the major extent. There was no educational conferences which is really the field we are in here and we try to get the doctors together for conferences.

Ms. Lavine:

I see. In other words you were discussing with her current claims that Doctor Matanky or Corbin Medical Clinic would supply.

Dr. Sherr:

At that particular time.

Ms. Lavine:

I see. That's been the past three or four

years or so?

Dr. Sherr:

I think so, yes.

Ms. Lavine:

Thank you. Now if I understand your testimony correctly, you weren't concerned with the billing rates so much as you were concerned with the appropriateness of the visit when you were reviewing the claims. Is that correct?

Dr. Sherr:

That's correct.

Ms. Lavine:

I don't think I have anything further at this point in time.

Mr. Schochet:

Mr. Jefsen.

Mr. Jefsen:

Not of Doctor Sherr at this time.

Mr. Schochet:

Alright, before I forget, may I have those three parts of Exhibit B. I read them into

the record but I didn't identify them in my notes.

Ms. Lavine:

Certainly. I would like to object to them on the grounds that they have not been published in the federal register pursuant to Title V of Section . . Title V United States Code Section 552.

Mr. Schochet:

Would you give me that code reference again.

Ms. Lavine:

Yes, Title V United States Code Section 552. That's the basic provision requiring publication.

Mr. Schochet:

We'll take that under consideration. It's on the record.

Ms. Lavine:

Thank you. Of course then my follow-up objection that those provisions are irrelevant to these proceedings and could not be considered to adversely .. could not be considered as

affecting Doctor Matanky adversly, as provided for in Title V Section . . .

Mr. Schochet:

Do you mean they could be considered at all? Or just not considered adversly?

Ms. Lavine:

The way I understand it the code section they could not affect Doctor Matanky at all.

Mr. Schochet:

So that's an absolute objection then.

Ms. Lavine:

Yes.

Mr. Schochet:

OK. What's next for the . . . I think we should have some explanation from the carriers representative you suggested that Mr. . . .

Mr. Jefsen:

Yes I think maybe so that everybody understands the procedure that is utilized in review, I'll let Mr. Molaison explain the summary in

general term exactly what happens to the claims after they have been reviewed by Doctor Sherr.

Mr. Molainson:

Mr. Jefsen, I'd like to go back a bit because Ms. Lavine keeps using alot of quotes from the Federal Regulations which and now she seems to want to feel that everything should be published in the Federal Register. Title XVIII of the Social Security Act, Section 1862 (a)(1) denies coverage for services that are not reasonable and necessary, and I'm really not prepared to give you the exact regulations and guidelines that they are under that spell out what carriers are supposed to do in applying this one provision of Title XVIII. But, from there Carriers are instructed to insure that payments are not made for services that are not reasonable and necessary, and in applying this, these regulations there, they are to establish various guidelines to use in

adjudicating claims. One of the other provisions says that services are to be paid in accordance with the general practice in the community and or the carrier is to use standards of the community in order to help determine what is reasonable and necessary. In applying that principle the carrier has established what we refer to as peer group norms, which are guidelines that we've developed indicating what we, what is considered normal in the community as to what is reasonable and necessary to expect a physician to bill. This is the basis for the PARE cases, excuse me, a little internal jargon, payment review project cases, which is what Doctor Matanky fell under originally. For exceeding the peer group norms, as established for nursing home visits, caused his claims to suspend, not to suspend, but caused his claims to be questioned as to the necessity for the services. I have some guidelines which were not published anywhere. Internal guidelines that were developed by Blue Shield

and these go back to December 15, 1966 and were from the then Chief Medical Advisor of Blue Shield as guidelines to be applied to nursing home visits. They stated, when the following conditions are mentioned the visits are to be paid as billed by the doctor without medical review; and basically with going through the 14 diagnoses given, they, they've referred to acute conditions, cardiac failure insufficiency, that type of thing. If you would like to look at them, I would be happy to let you look at them; but the basic idea is that any servere condition that would require the attention of the physician on more than once a month basis.

Doctor Matanky's claims did indicate these conditions, or conditions sufficient to justify the visits that were originally allowed. As Doctor Sherr pointed out when you look at them on a claim by claim basis, the necessity seemed to be there. It was only when you start comparing the practice to the peer group norm that you see

these and pull out a series of claims from months on end of service that the conditions, the diagnoses, repeat month after month acute, acute. You mentioned. . . are there any questions on that Mr. Schochet before I continue?

Mr. Schochet:

I have no questions.

Mr. Molaison:

You talked about the time limitations on re-openings and that as far as you could determine there was a, I may, I don't want to misquote you but there was nothing published before December 71 regarding going back three years prior, something to that effect. Again I don't have the specific references but I've read these regulations so many times I practically could quote them. The regulations entitled in the code of federal regulations, number V, there is a statement that reopening may be made at anytime under the circumstances of fraud or similar fault. Now the issue of

fraud was not used in adjudicating these claims, but remember the carriers are contracted by the Medicare Bureau to follow their instructions and their instructions are contained in the Medicare Carrier's Manual which I think we've referred to before, not in the hearing, but in correspondence. There is a section in the Medicare Carrier's Manual Section 121.00 which defines similar fault as a pattern of billing for, well I can't remember the exact quote, services that are not reasonable and necessary. Again as going back to the same point of the carriers operating under contract with the United States Government to do what the United States government tells us to do, we were instructed as the carrier by the Regional Office of the Bureau of Health Insurance of the Health Care Financing Administration of the HEW to do this review. And I have a letter which I think probably should be admitted into evidence. Mr. Schochet, May 1974 it's in the . . .

Mr. Schochet:

It is now admitted into the record as Exhibit C a photostatic copy of the May 1974 letter which purportedly directs the carrier involved to conduct this audit and review, is that correct.

Mr. Molaison:

Yes sir, that's correct

Mr. Schochet:

And copies have been furnished to the attorney for the claimant and the carrier's attorney.

Mr. Molaison:

I might point out for Ms. Lavine's information and clarification on the basis any misunderstanding that the current Medicare Bureau of the Health Care Financing Administration was at that time the Bureau of Health Insurance of the Social Security Administration, in case there has been any confusion.

Ms. Lavine:

Excuse me your honor, I object to this as

irrelevant. Doctor Matanky was given no notice of "unintelligable" as far as I can see.

Mr. Schochet:

It will be noted but it will probably be over ruled because I think that there is notice to Doctor Matanky early in the file of the early 70's of the review.

Mr. Jefsen:

I would also point out, if you want to follow it up with the next letter, there is reference to the fact that the Department of Health, Education and Welfare had previously notified Mr. Lavine of the action that they were telling the carrier not to undertake it, in the second paragraph in the letter. I'll see if I can locate a copy of that letter. And that letter to which I think that we have references a letter dated May 15, 1974 which is number 4 in the first volume that's been entered in the . . .

Ms. Lavine:

Say the page number.

Mr. Jefsen:

It's number 4, number 3 and 4.

Mr. Schochet:

Are you through Mr. Molaison?

Mr. Molaison:

I am.

Mr. Schochet:

Your question was as to the nature of the review?

Mr. Jefsen:

Right. What occurs with respect to the review as we process, as we move from completion of the medical advisor state into the stage of the computation actually in the dollars included.

Mr. Molaison:

The medical advisor, I think as Doctor Sherr has pointed out, strictly determines what procedures are reasonable and necessary, what RVS number should be used, how many treatments

to allow, so forth. It then goes to a clerical person who makes the calculations based on Medicare's reasonable charge criteria in effect at the time the services were rendered. And they do the calculating of how much money was allowed and should have been allowed and the recoupment that is done which is your file number 2.

Mr. Jefsen:

Just so that we understand all that Mr. Moliasen is saying, the method by which the dollar value is placed upon it is to pay that amount which is established by the practice within the community.

Mr. Molaison:

Well the level of care is determined according to the practice in the community and also the reasonable charges are developed according to the practice in the community. The doctor of course establishes his own customary charge for a particular service, but the prevailing

charge is then developed from the charges of all physicians in the same specialty in the area and the claims are paid of course of the lesser of the billed amount, the customary or the prevailing. I don't think there was any question in the carrier's mind as to the fees charged by Doctor Matanky on a peer service basis. I think we allowed $14.00 for a visit which is, that was in 69, so and then it went up to $20 I think. Doctor Sherr would you agree with that, that these fees were rather reasonable.

Dr. Sherr:

Well, in the area he is practicing in I think that they're fairly reasonable. My area they weren't, nevertheless they are in that area. Because we encourage the doctor to put down the usual and customary fee. The fee that he charges a private patient you see.

Mr. Jefsen:

I have no further questions Ms. Lavine.

Ms. Lavine:

Oh, Mr. Molaison

Mr. Schochet:

M O L A I S O N.

Ms. Lavine:

Oh that's right. I'm thinking of . . . french?

Mr. Schochet:

You're getting hungry.

Ms. Lavine:

Probably. That's a very acute medical diagnosis.

Mr. Schochet:

Medical - Legal.

Ms. Lavine:

I would like to direct your attention to the basis for reviewing the claims. I understood Mr. Jefsen to say that there was no dispute about whetherDoctor Matanky had actually made these visits and would agree with him for the purpose for this hearing, you were not contesting his actually having made the visits. Is that correct?

Mr. Molaison:

That's correct.

Ms. Lavine:

And so your disputes are on other lines. Is that correct? With Doctor Matanky over his billing.

Mr. Molaison:

We aren't questioning whether or not the services were actually rendered. We are questioning only whether or not there was medical necessity for the services rendered.

Ms. Lavine:

I see, and there is no, that's the only basis. It's not how much he charged.

Mr. Molaison:

Correct.

Ms. Lavine:

And are you the person who had some say after Doctor Sherr as to whether or not a visit was medically necessary?

Mr Jefsen:

I'm going to kind of object a little bit, because really, if I understand it correctly, medical decisions are made by medical people, and the question as to whether or not a visit is documented on the claim, and that's what we're talking about, I don't know, I don't particularly want to raise that question as to whether or not, quote, they're medically necessary. I'm saying the question presented to Doctor Sherr and you tell me, Doctor Sherr, to be sure I interpret you right, does the claim and information on the claim support the medical necessity of the services rendered, or the RVS number assigned to those medical services, and if it doesn't, then it has to be lowered or rejected. Is that correct?

Doctor Sherr:

That's correct and may I enlarge on it for just a second, because its important that we understand this. The claims of Doctor Matanky

were looked at and checked by a medical advisor who is a peer of Doctor Matanky's. Who has a practice almost identical to Doctor Matanky's for instance, an orthopedic surgeon wouldn't dare look at these claims, he wouldn't be allowed to, an ENT man wouldn't be allowed to. It's only one who is one of your peers because you are judged by the peer group normal, as was brought up earlier.

Ms. Lavine:

You are the peer, right?

Dr. Sherr:

That's correct. So consequently we have a number of general practitioners, in a similar type of practice, who did and do have patients in sanitariums, hospitals and all sorts of private calls. And it is that kind of a practitioner that is allowed to review those claims.

Ms. Lavine:

I see. You are the peer who was reviewing

the claims involved in this hearing.

Dr. Sherr:

I think that I did most of the reviews.

Ms. Lavine:

So it was your say so as to whether or not a visit was medically necessary. Is that correct?

Dr. Sherr:

Whether it was medically necessary and fitted the guidelines that were given to us.

Ms. Lavine:

I see.

Dr. Sherr:

Medicare Medi-Cal.

Ms. Lavine:

And then, Mr. Molaison, your only testifying to the procedure that was used in Blue Shield to process these claims. Is that correct?

Mr. Molaison:

Correct.

Ms. Lavine:

Your in effect saying to me that Blue Shield didn't follow any time limits on review. Is that correct?

Mr. Molaison:

We followed the time limit that the Medicare Bureau instructed us to follow, which was go back to and review all the claims from 1966 to the present, which was then 1974. We didn't go all the way back to 1966 because we were not able to obtain the records. In fact the bulk of the claims did not go that, well, it started in 1967 and then we went forward from there to 1973, I believe it was.

Ms. Lavine:

So what your saying is you didn't follow any particular regulations published in the federal register but just for what you were told to do through interoffice memorandums or whatever. Is that correct?

Mr. Molaison:

Regulations as to each and every coverage issue determination are not published in the federal register. It would be a sheer impossibility. These are regulations and guidelines that are established by the, well, the guidelines were established by the carrier for services prior to January 1, 1971 and the guidelines prior to that were by the carrier; subsequent to that were Medicare regulations which had been issued.

Ms. Lavine:

So what your saying is that you followed some kind of guidelines and a some kind of communication from the Social Security Administration asking you to review claims in which payments had already been made. Is that correct?

Mr. Molaison:

Correct.

Mr. Jefsen:

Let me back up, had payments been made in '71. I guess they had been up through that period of time. Your right. . .OK

Mr. Schochet:

I think the right word is they're directing review, not requesting. Because there was not any initiative on the part of the carrier, it was ordered by the central and national authority.

Ms. Lavine:

As I understand it, correct me, did the Social Security Administration notify any patient that a review of his claims would occur after payment had been made?

Mr. Molaison:

Just the ones that they audited as . . . and contacted as part of the indictment. As far as I know.

Ms. Lavine:

Is it your position that these people were

actually contacted?

Mr. Molaison:

The information given to us says they were.

Ms. Lavine:

Well I'd like to make a statement at this time. I interviewed many of those people personally but. . . and the people for the most part indicated to me that they had no knowledge . . .

Mr. Schochet:

What people?

Ms. Lavine:

The people involved in the indictment.

Mr. Schochet:

Now just a minute I think we should establish there were those people billing Medicare directly or was the billing done by the doctor?

Ms. Lavine:

I believe the billing was being done by the doctor. Is that correct?

Dr. Matanky:

Thats correct.

Mr. Schochet:

Then your talking about the patient beneficiaries where they were notified when the billing was from the doctor and normally as I understand the practice is for the carrier to notify only the doctor. Is that right?

Mr. Jefsen:

Yes and I may be wrong and I'll stand subject to correction, especially going back in that period of time. As I understand it, if a doctor accepts a Medicare patient and accepts the assignment . . .

Mr. Schochet:

These were not assigned claims were they?

Dr. Matanky:

Yes.

Mr. Schochet:

They were?

Dr. Matanky:

Yes.

Mr. Schochet:

I thought they were not.

Mr. Jefsen:

Oh yes, he accepts the assigned claim and takes them as an assignment, that the beneficiary then has nothing to do with it.

Dr. Sherr:

However, Medicare generally lets the beneficiary know.

Mr. Jefsen:

Yes, that's true.

Dr. Sherr:

This is not a bill. Because that tells them what the transaction was and how much was paid to the physician.

Mr. Jefsen:

Yes.

Mr. Schochet:

And again normally on a case like that, that

does not mean any liability on the part of the patient if the doctor accepts assignment. He accepts assignment as whatever he gets as payment in full subject to further deduction over the usual 20% for deductibles for co-insurance. Is that correct?

Mr. Jefsen:

That's my understanding.

Dr. Sherr:

I might say as a physician I personally would object to several dozen patients being notified that claims are being reevaluated checked and so on. I kind of would be disturbed about that. They'd wonder what's going on. What am I doing.

Dr. Matanky:

If I can answer this as an ongoing thing, with me continuously and these, in this particular audit none of these patients were notified. And if I am correct, a visit that is not allowed by Medicare then according to

your rules and regulations I can then go and bill that patient for that visit.

Mr. Schochet:

For services not covered.

Dr. Matanky:

For services, but when a visit is not covered. See they have the right to reduce the amount of money that they feel should be paid but then when they completely eliminat a visit, then like when they go from four visits to two visits. Then those two visits that are completely eliminated according to their own rules and regulations, I am allowed to bill that patient for that service. So therefore, the beneficiary is really very much involved because if there are visits that are not allowed, then that beneficiary is responsible for those and I can bill that patient.

Mr. Schochet:

Without being final about it I would question that as an absolute statement, Doctor Matanky.

For example, supposing there has been surgery and you have a so called global fee and there is a consultation that was billed but or a later visit which is included in the global fee but the doctor has billed for it. That is not a covered service and he would have no way to collect for that.

Dr. Matanky:

Well your talking about surgery, I'm talking about medical.

Mr. Schochet:

I'm talking about cases I've heard.

Dr. Matanky:

Ok but medical visits.

Mr. Schochet:

I don't like flat rules.

Dr. Matanky:

Ok I understand, but this is what I have been informed and correct me if I am wrong, and that would have to be according to their own rules and regulations, and this is what is

being promulgated by instruction to my personnel, and Carmen is the one who specifically said that, she came from UCLA, got an 'A' in her course and was told that specific fact.

Mr. Jefsen:

I think that in part your right and in part your wrong and where you have the difficulty is exactly the example that you gave quote "What is a covered service." If you render a service which is not a covered service, and then you erroneously somehow bill Medicare for and the bill comes back and is not paid, that's fine. I have a real question in my own mind that if your treating a patient, for an ongoing geriatric problem at a convalescent home or at an extended care facility home, that that whole course of treatment is "A covered service" and if you over-utilize or can't justify the utilization above and beyond the guidelines, quote, they're going to treat that whole period of interment as a covered

service and not allow you to bill for the one visit we didn't pay.

Dr. Matanky:

That is incorrect. Now I would suggest that you look at your own rules for any . . .

Mr. Schochet:

Ok gentlemen let's stop it right then and there. There is a difference of opinion, it's not pertinent right here. I think your both under the moral duty to look it up and clear your own minds on it and if you can, clear mine too.

Dr. Sherr:

It is considered, by most doctors, that if the guidelines say that one visit per month on a chronic patient is sufficient, then the other services, the other visits are not considered pertinent and payable visits. On the other hand if it is documented, the patient has a very serious or acute problem whatever the reason is that you really have to go there,

that is a payable service.

Dr. Matanky:

Well that is not the point that I'm bringing up.

Mr. Schochet:

He is talking about being able to collect on the side legitimately from his patients.

Dr. Sherr:

Well they are not payable visits according to . . .

Mr. Schochet:

Ok there is a difference in opinion that is not pertinent here, so lets drop it and continue.

Ms. Lavine:

Now wait a minute, Doctor Matanky.

Dr. Matanky:

Ok.

Ms. Lavine:

He's made a ruling.

Mr. Schochet:

You have a question for Mr. Molaison?

Ms. Lavine:

Yes. Mr. Molaison I have one other question to ask you. Were the patients concerning whose claims were coming in after the point in 1971 when no payment was being made to Doctor Matanky. What kind of notice was given to those patients concerning payment to Doctor Matanky?

Mr. Molaison:

I really don't know exactly what the notification would have said.

Ms. Lavine:

Well, were they notified that he had actually been paid?

Mr. Molaison:

As I said I don't.

Ms. Lavine:

You don't know at all?

Mr. Molaison:

I don't know. I would have to check with some . . .

Ms. Lavine:

You have any means of records, of record keeping?

Mr. Molaison:

I'm sure I could check with some of our internal people who deal in this matter directly and find out . . .

Mr. Schochet:

I think I for sure answered that a few minutes ago. Saying that in many cases where the payment goes right to the doctor and Doctor Matanky is nodding his head, yes. The patient gets a copy of the staement forwarding the amount paid by Medicare to the attending physician but across of the stamp in big visable letters is this is not a bill. And it shows the amount billed by the doctor, the amount considered by Meeicare less the deduction and the net amount at the bottom of this page. So I think that would answer that question although not by Mr. Molaison.

Ms. Lavine:

Well, my problem is that of course after 1971 for a quite period of time Doctor Matanky was given no payments at all. My question was meant to inquire about what kind of notice was given to those patients about whether payment had been made or whether it was being withheld. The reason I ask this, your honor, is that I think those people were entitled to know whether or not their medical services were being paid for and if they weren't being paid for, then they had a right to know that in order to make other arrangements.

Mr. Schochet:

Even if the claims were assigned?

Ms. Lavine:

I think so.

Mr. Schochet:

And you testified I believe or stated earlier, not testified, stated earlier that you had

consulted a number of patients yourself had you?

Ms. Lavine:

May I make a complete statement on that. I really wasn't complete on that.

Mr. Schochet:

I understood you to indicate that you had consulted a number of patients and that you received information from them.

Ms. Lavine:

Yes. Not in this, these claims were involved in this hearing. It was on the . . .

Mr. Schochet:

It was on another case?

Ms. Lavine:

On the claims that were not involved in this, because . . .

Mr. Schochet:

Well then the whole thing was irrelevant and what you said was improperly stated and put into this record.

Ms. Lavine:

Well it was in response to matters discussed by other counsel.

Mr. Schochet:

Well, that's why I try to keep things pertinent. Go ahead.

Ms. lavine:

I appreciate that. That's not . . .

Mr. Schochet:

See it's a misleading statement because otherwise somebody would think that you interviewed these patients involved here. That's what we're here for today.

Ms. Lavine:

I appreciate that but I was responding to what Mr. Molaison was talking about.

Mr. Schochet:

Was that your last question for Mr. Molaison?

Ms. Lavine:

For right now it is, yes.

Mr. Schochet:

Do you have anything else Mr. Jefsen?

Mr. Jefsen:

I have, I'd only offer one more letter of December 9th again just so the whole matter is before this hearing and I think that may already be a part of your file though I couldn't find it in my duplication and it's just a letter of December 9, 1969, again to the doctor, by one of the medical advisors of Blue Shield indicating that at that time the one visit per month rule was, in essence, the one visit per month guideline was applicable.

Mr. Schochet:

This will now be admitted as Exhibits D, being as stated by Mr. Jefsen, a photostatic copy of a December 9, 1969 letter to Doctor Matanky from Doctor Riley a Blue Shield Medical Advisor. I don't recall if that is in the file or not, we'll check that later. If not then we can have a copy made.

Ms. Lavine:

I would appreciate that because I don't believe it is in the compilation that we received so far. I would object this on the grounds of irrelevancy because it does not appear to limit, apply to Medicare but appears to apply to Medi-Cal matters which are beyond the scope of these proceedings.

Mr. Schochet:

May I ask aren't a great many of these claims Medi Medi?

Mr. Jefsen:

A great number of the claims are combinations back and forth and my purpose, the scope of my purpose, in putting the letter into evidence is again to show that we're not talking, what I think of, as a lawyer as a hard fast rule and regulation. We're talking really about guidelines trying to help providers under the program to have some means as to what quote will be utilized to determine what is medically

necessary and what is not. And if an applicable of Medi-Cal is basically going to be along the same lines as Medicare if it's "medically necessary" under one, certainly it is going to be medically necessary under the other and if it is questionable under one it might be questionable under the other.

Mr. Schochet:

Alright who is next with something should be on the record?

Ms. Lavine:

Of course, your honor, we do object to and oppose the statements that Mr. Jefsen has just made concerning . . .

Mr. Schochet:

I'd assumed that.

Ms. Lavine:

Thank you.

Mr. Jefsen:

I have nothing further your honor.

Mr. Schochet:

Do you have anything Mr. Molaison?

Mr. Molaison:

No, I cant' think of anything.

Mr. Schochet:

Doctor Sherr is there anything else that you could contribute to this material that we should know?

Dr. Sherr:

No, not with regard to these claims.

Mr. Schochet:

Well that's what your here for and now Ms. Lavine you have with your father a great many rather somewhat numerous letters in the file containing some ominous sounding common and legal arguments about due process, deprivation of property, right to property, lack of notice lack of publication and according satisfaction which you quoted California Law and so on. Do you want to send us a written summary on it. The reason I suggest written

summaries in cases of they type, is that from my own fairly extensive experience as a lawyer you can think of something now and then on the way home, bingo you left something out. So I would rather have somebody grab something and then look it over the next day or even a third day and then feel that they've got it pretty well wrapped up and then send it in and call it quits on that deal because we can't keep it open any longer you know that.

Ms. Lavine:

I agree with you. I think that would be most advisable. You've asked me about certain copies of matters here that I hope will be much more helpful to you if I have them here or have them as an argument and we would like you to do a little research and give you this citation of Goldberg vs Kelley and discuss the various . . .

Mr. Schochet:

Well I'll find that out. I just thought you had it handy. Lord knows I've discussed Goldberg vs Kelley numerous times within the last what was it about of the earlier '70s wasn't it. Anyway it was quoted extensively and I remember the disability cases too. But with what you have in the file, with what you've put in the record today, I would think that you should be able to send it to us in a week.

Ms. Lavine:

That's fine. Now where shall I send it to?

Mr. Schochet:

Well after your sending, nature takes its course it goes in different directions depending where I am at the time. So you send it to the San Francisco office and its called to my attention. Mr. Jefsen would you like the same privilege?

Mr. Jefsen:

Alright, I will take a look. I'm not sure that a response will be necessary. We've already covered on that say, we've talked about it; but I will take a look and get back to you in about a week.

Mr. Schochet:

I want you to have the same opportunity. As you understand, I'm impartial, I am on a contract to do exactly what I think is right, which isn't necessarily for one side or for the other and that's my practice. I'll ask again does anybody have anything else to put into the record that they think is pertinent that has not been put in already, and of course it is assumed that all the laws, rules and regulations are part of the file by virtue of their nature. If you have anymore references, please put thim in now. I notice that some of the libraries in the city are not complete, for example, UCLA Library does not

have the CCH on the Medicare, Medica. . . Well on that note and I assume to the surprise of everyone present, the hearing is being closed at 11:50 a.m., this 7th day of August, 1978. Now there will be time of course allowed for receiving the briefs, after that I do not know, this is not such a simple matter, for some of these cases it is very simple, but now we have to be sure that the rules are as they are alleged by the carrier, and some have been questioned and denied . . . on behalf of the claimant . . . The research is going to be an arduous task at least so far as I'm concerned; but as soon as it can be done, a decision will be issued and copies will be sent to both parties and I thank you all for bein here this morning. I am glad that we were finally able to get together and I hope that you have everything in the record now, and please take all of those big boxes with records out of the room and let me see them no more. On that note the hearing is closed. Thank you.

20 CFR, Part 405 as published in the Federal Register, Volume 37, No. 2, January 5, 1972, pages 89-91

Social Security Administration

[20 CFR Part 405]

(Reg.No.5]

FEDERAL HEALTH INSURANCE FOR THE AGED

Provider Review Procedures and Suspension of Payments Under Medicare

Notice is hereby given, pursuant to the Administrative Procedure Act (5 U.S.C. 552 et seq.) that the amendments to the regulations set forth in tentative form below are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. The proposed amendments (1) require intermediaries to institute review procedures for providers dissatisfied intermediaries' determinations on cost reports; and (2) provide that payments to providers and

suppliers of services could be suspended to recover overpayments to them only after such providers and suppliers have been afforded an opportunity to present evidence on the issue of the overpayment, and where a suspension of payments is put into effect there would be an expeditious settlement of the issues involved. It is intended that regulations dealing with provider reviews be effective for cost reporting periods ending on or after December 31, 1971, and that the regulations on suspensions be effective January 1, 1972.

* * *

The proposed regulations are to be issued under the authority contained in sections 1102, 1815, and 1871, 49 Stat. 647, as amended, 79 Stat. 296, 322, and 331, as amended; 42 U.S.C. 1302, 1395 et seq.

Dated: December 2, 1971.

Robert M. Ball
Commissioner of Social Security

Approved: December 29, 1971.

ELLIOT L. RICHARDSON,
Secretary of Health, Education,
and Welfare.

Regulation No. 5 of the Social Security Administration (20 CFR Part 405) is further amended as follows:

1. The heading to Subpart C is revised to read as follows: Subpart C--Exclusions, Recovery of Overpayment, Liability of a Certifying Officer, and Suspension of Payment.

2. Section 405.301 is revised to read as follows:

§ 405.301 Scope of subpart.

Sections 405.310 to 405.320 describe certain exclusions from coverage applicable to hospital insurance benefits (part A of Title XVIII) and supplementary medical insurance benefits (part B of title XVIII). The exclusions in this subpart are applicable in addition to any other conditions and limitations in this part 405 and in title XVIII of the Act. Sections 405.350 to 405.359

relate to the adjustment or recovery of an incorrect payment, or a payment made under section 1814(c) of the Health Insurance for the Aged Act. Sections 405.370 to 405.373 relate to the suspension of payments to a provider of services or other supplier of services where there is evidence that such provider or supplier has been or may have been overpaid.

3. New §§ 405.370-405.373 are added to read as follows:

§ 405.370 Suspension of payments to providers of services and other suppliers of services.

(a) Payments otherwise authorized to be made to providers of services and other suppliers of services in accordance with subpart A or subpart B of this part 405 (but excluding payments to entitled individuals and payments under § 405.251 (a) may be suspended, in whole or in part, by an intermediary or a carrier when:

(1) The intermediary or carrier has determined that the provider or other supplier to whom such payments are to be made has been overpaid under the XVIII of the Social Security Act, or

(2) The intermediary or carrier has some evidence, although additional evidence may be needed for a determination, that such overpayment exists or that the payments to be made may not be correct.

(b) A suspension shall be put into effect only after the provisions in §§ 405.371 and 405.372 have been complied with and the intermediary or carrier has determined that the suspension of payments, in whole or in part, is needed to protect the program against financial loss. The provisions of this section and §§ 405.371-405.373 shall be effective on January 1, 1972.

§ 405.371 Proceeding for suspension.

(a) General. Whenever the intermediary

or carrier has determined that a suspension of payments under § 405.370 should be put into effect with respect to a provider of services or other supplier of services, the intermediary or carrier shall notify the provider or other supplier of its intention to suspend payments, in whole or in part, and the reasons for making such suspension. The provider or other supplier will be given the opportunity to submit any statement (including any pertinent evidence) as to why the suspension shall not be put into effect and shall have 15 days following the date of notification to submit such statement, unless the intermediary or carrier for good cause imposes a shorter period. The intermediary or carrier may, for good cause shown, extend the time within which the statement may be submitted. If no statement is received within the 15-day period or such other period as specified in the notice, the suspension shall go into effect.

(b) Fraud or misrepresentation. The provisions of paragraph (a) of this section shall not apply where the intermediary or carrier has reason to believe that the circumstances giving rise to the need for a suspension of payments involves fraud or willful misrepresentation. Instead, the intermediary or carrier may suspend payments without first notifying the provider or other supplier of an intention to suspend payments. The provider or other supplier will be notified of such suspension and the reasons for taking such action.

(c) Notice of amount of program reimbursement. The provisions of paragraph (a) of this section shall not apply where the intermediary, after furnishing a provider a written notice of the amount of program reimbursement pursuant to § 405.491, suspends payment under paragraph (b) of such § 405.491.

* * *

§ 405.372 Submission of evidence and notification of administrative determination to suspend.

When pursuant to § 405.371(a) the provider or other supplier submits a statement, the intermediary or carrier shall consider such statement (including any pertinent evidence submitted), together with any other material bearing upon the case, and make a determination as to whether the facts justify a suspension authorized by § 405.373. If the intermediary or carrier determines that a suspension should go into effect, written notice of such determination will be sent to the provider or other supplier. Such notice will contain specific findings on the conditions upon which the suspension was based, and an explanatory statement for the final decision.

§405. 373 Subsequent action by intermediary or carrier.

(a) Where a suspension is put into effect

by reason of § 405.370(a), such suspension shall remain in effect until (1) The overpayment is liquidated, (2) the intermediary or carrier enters into an agreement with the provider or other supplier for liquidation of the overpayment, or (3) the intermediary or carrier, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment; except that the intermediary or carrier may at any time adjust such suspension for an appropriate period if it determines that continuation of the suspension would cause irreparable harm to the provider or other supplier.

(b) Where the suspension is put into effect by reason of § 405.370(b), the intermediary or carrier will take timely action after such suspension to obtain such additional evidence it may need to make a determination as to whether an overpayment exists or the payments may be made (i.e., evidence from the records of the provider or other supplier of services).

All reasonable efforts will be made by the intermediary or carrier to expedite such determinations. As soon as such determination is made, the provider or other supplier will be informed and, where appropriate such suspension will be rescinded or adjusted to take into account such determination. If such suspension is not rescinded, it shall remain in effect as specified in paragraph (a) of this section.

(c) The provisions of this section shall not apply where the intermediary or carrier, in suspending payments pursuant to § 405.370, had reason to believe that the circumstances giving rise to such suspension involve fraud or serious misrepresentation.